Bureau of TennCare/Medicaid
Provider Enrollment

310 Great Circle Road
Nashville, TN 37243-1700

TENNESSEE DEPARTMENT OF FINANCE AND ADMINISTRATION
NO. 2 INDIVIDUAL APPLICATION
www.state.tn.us/tenncare/Providers/enroll.html

Complete Name: _____ **Title:** _____
(As Shown on License) **(M.D., D.D.S., etc.)**

(Check All That Apply)	_____ **Change of Ownership**
_____ **New Enrollment**	_____ **Reactivation**
_____ **MCC Medicaid No.**	_____ **Adding Practice/Satellite Location**
_____ **Medicare/Medicaid No.**	_____ **Name Change and Tax ID # Change**
Practice Location Address (No P. O. Box #)	**Pay-To Name & Address** (as shown on the I.R.S. and W-9 Form)
Street: _____	**Legal IRS Name:** _____
City: _____	**Name (cont'd)** _____
County: _____	**D/B/A Name:** _____
State: _____	**Street:** _____
Zip Code + 4: _____	**City:** _____
Telephone #: _____	**State:** _____
Fax Number: _____	**Zip Code + 4:** _____
	Telephone #: _____

Federal Tax No. (IRS No.): _____ **Social Security No. (req'd):** _____

Federal Medicare No.: _____ **State Medicaid No.:** _____ **NPI No.:** _____

Medical Specialty: _____

Taxonomy: _____, _____, _____, _____

Briefly describe the services you propose to offer to Medicaid recipients: _____

_____

_____

Board-Certified (Y/N): _____ **Board-Eligible (Y/N):** _____

Name of Board: _____ **DEA No.:** _____

Certificate No.: _____ **Date of Issuance:** _____
Month / Day / Year

Hospital-Affiliated (Y/N): _____ **Hospital-Based (Y/N):** _____

Name of Hospital: _____

Submit copies of professional licenses, and/or certifications, specifically required to operate as a health care provider.

State License No.: _____ **Date Of Issuance:** _____
Month / Day / Year

Have you or any other owner, managing director, etc., related to this application ever been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or the Title XX services program since the inception of those programs? Yes ____ No ____. If yes identify those person(s) by name and provide specifics for Medicaid evaluation. Attach this information to this application.

Please list the full name of every owner, with Social Security number and percent of ownership (required). If owned by corporation, please list corporate officers with same information. Use additional paper ,if necessary.

	Name	Title	SSN	% Ownership
1)				
2)				
3)				
4)				
5)				
6)				
7)				
8)				
9)				
10)				

EFFECTIVE DATE FOR OPENING/REOPENING OFFICE: _____

EFFECTIVE DATE OF CHANGE OF OWNERSHIP: _____

If change of ownership, please provide the following:

Previous TN Medicaid Provider No. (if any): _____

Previous Name: _____

Street Address: _____

City: _____ **State:** _____ **Zip Code + 4:** _____

IF A CHANGE OF OWNERSHIP HAS OCCURRED, DO NOT BILL ANY CLAIM FOR DATES OF SERVICE ON OR AFTER THE DATE OF OWNERSHIP CHANGE UNTIL YOU ARE NOTIFIED THAT THIS APPLICATION HAS BEEN ACCEPTED AND ENROLLMENT HAS BEEN COMPLETED. FAILURE TO FOLLOW THIS PROCEDURE MAY RESULT IN RECOUPMENT OF CLAIMS PAID.

Application Surety Statement: "I certify that the information provided on this application is complete and correct to the best of my knowledge."

Provider's Original Signature: _____ **Date:** _____

Printed Name: _____ **Title:** _____

If you belong to a group and authorize all monies due be made payable to the group, please indicate the name and provider number of said group and sign below.

_____ _____

Group Name **Medicare Group Provider No.**

Provider's Original Signature: _____ **Date:** _____